		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0008201

Facility Name: Du Page Convalescent Center

Address: 400 North County Farm Road (Number) Wheaton, Illinois (City) 60187 (Zip Code)

County: Du Page

Telephone Number: (630) 665-6400 **Fax #** (630) 665-2446

IDPA ID Number: 36-6006551-002

Date of Initial License for Current Owners: Prior to 1935

Type of Ownership:

	VOLUNTARY,NON-PROFIT		PROPRIETARY	X	GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership	X	County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Patrick Szajkovics **Telephone Number:** (847) 259-7373, Ext. 111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from Dec. 1, 2000 to Nov. 30, 2001 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) Beth McGowan Welch
(Title) Deputy Administrator

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) Patrick Szajkovics, Consultant
(Firm Name & Address) Strategic Reimbursement, Inc. 3315 W.Algonquin Rd. S.110 Rolling Meadows,IL 60008
(Telephone) (847) 259-7373 Fax # (847) 259-9869

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: Dec. 1, 2000 Ending: Nov. 30, 2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	508	Skilled (SNF)	508	185,420	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	508	TOTALS	508	185,420	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	122,418	30,643	10,783	163,844	8
9	SNF/PED					9
10	ICF	2,474	104	0	2,578	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	124,892	30,747	10,783	166,422	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.75%

D. How many bed-hold days during this year were paid by Public Aid? 824 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
Meals on Wheels, Empl.meals, Empl.Pharmacy, Empl.Therapy, County Laundry

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started Pre - 1935

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 50 and days of care provided 7,576

Medicare Intermediary Mutual of Omaha Insurance Company

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 11/30/2001 Fiscal Year: 11/30/2001

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Du Page Convalescent Center # 0008201 **Report Period Beginning:** Dec. 1, 2000 **Ending:** Nov. 30, 2001

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	A. General Services											
1	Dietary	1,551,802	579,168	18,044	2,149,014		2,149,014	(471,233)	1,677,781			1
2	Food Purchase		930,383		930,383		930,383	(204,013)	726,370			2
3	Housekeeping	962,470	174,669	65,097	1,202,236		1,202,236		1,202,236			3
4	Laundry	252,371	122,319	282,049	656,739		656,739	(2,944)	653,795			4
5	Heat and Other Utilities			1,456,293	1,456,293		1,456,293		1,456,293			5
6	Maintenance			597,059	597,059		597,059	(43,776)	553,283			6
7	Other (specify):*											7
8	**TOTAL General Services**	2,766,643	1,806,539	2,418,542	6,991,724		6,991,724	(721,966)	6,269,758			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	12,324,722	807,971	406,833	13,539,526	(712,462)	12,827,064		12,827,064			10
10a	Therapy	560,442	19,352	588,588	1,168,382		1,168,382		1,168,382			10a
11	Activities	549,709	27,897	877	578,483		578,483		578,483			11
12	Social Services	306,359	2,154	2,620	311,133		311,133		311,133			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	13,741,232	857,374	998,918	15,597,524	(712,462)	14,885,062		14,885,062			16
	C. General Administration											
17	Administrative	195,691		611,069	806,760		806,760	20,946	827,706			17
18	Directors Fees											18
19	Professional Services			154,057	154,057		154,057		154,057			19
20	Dues, Fees, Subscriptions & Promotions			117,915	117,915		117,915	(63,752)	54,163			20
21	Clerical & General Office Expenses	1,103,971	122,581	312,625	1,539,177		1,539,177	(3,864)	1,535,313			21
22	Employee Benefits & Payroll Taxes			3,392,529	3,392,529		3,392,529		3,392,529			22
23	Inservice Training & Education											23
24	Travel and Seminar			52,240	52,240		52,240	(3,017)	49,223			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			437,696	437,696		437,696		437,696			26
27	Other (specify):* Bad Debt Expense			416,555	416,555		416,555	(416,555)				27
28	**TOTAL General Administration**	1,299,662	122,581	5,494,686	6,916,929		6,916,929	(466,242)	6,450,687			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	17,807,537	2,786,494	8,912,146	29,506,177	(712,462)	28,793,715	(1,188,208)	27,605,507			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: Dec. 1, 2000 Ending: Nov. 30, 2001

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(43,776)	6		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(2,944)	4		8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	(20)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(73,302)	20		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(3,017)	24		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(416,555)	27		24
25	Fund Raising, Advertising and Promotional	(1,255)	21		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(393,333)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (934,202)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (934,202)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program	X		712,462	10	44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$ 712,462		47

Facility Name & ID Number Du Page Convalescent Center #0008201 Report Period Beginning: Dec. 1, 2000 Ending: Nov. 30, 2001

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			1,333,427	1,333,427		1,333,427	(4,402)	1,329,025			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,333,427	1,333,427		1,333,427	(4,402)	1,329,025			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	330,075	1,310,253	5,423	1,645,751	712,462	2,358,213	(19,722)	2,338,491			39
40	Barber and Beauty Shops	129,965			129,965		129,965		129,965			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee							278,130	278,130			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**	460,040	1,310,253	5,423	1,775,716	712,462	2,488,178	258,408	2,746,586			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	18,267,577	4,096,747	10,250,996	32,615,320		32,615,320	(934,202)	31,681,118			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

STATE OF ILLINOIS

Du Page Convalescent Center

ID# 0008201

Report Period Beginning: Dec. 1, 2000

Ending: Nov. 30, 2001

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Employee Reimbursements - other ancillary	$ (10,172)	39	1
2	Cafeteria Income - Food	(57,368)	2	2
3	Cafeteria Income - Other Costs	(132,510)	1	3
4	Catering Income - Food	(146,511)	2	4
5	Catering Income - Other Costs	(338,413)	1	5
6	Meals on Wheels - Food	(134)	2	6
7	Meals on Wheels - Other Costs	(310)	1	7
8	Provider Participation Fee	278,130	42	8
9	County Board Cost Allolcation	20,946	17	9
10	Other Misc Revenues	(2,589)	21	10
11	Drug Rebate credit reclassification	(9,550)	39	11
12	Drug Rebate credit reclassification	9,550	20	12
13	Bldg Depr difference - unlocated	(4,402)	30	13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(393,333)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: Dec. 1, 2000 Ending: Nov. 30, 2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	(471,233)	0	0	0	0	0	0	0	0	0	0	(471,233)	1
2	Food Purchase	(204,013)	0	0	0	0	0	0	0	0	0	0	(204,013)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(2,944)	0	0	0	0	0	0	0	0	0	0	(2,944)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(43,776)	0	0	0	0	0	0	0	0	0	0	(43,776)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(721,966)	0	0	0	0	0	0	0	0	0	0	(721,966)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	20,946	0	0	0	0	0	0	0	0	0	0	20,946	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(63,752)	0	0	0	0	0	0	0	0	0	0	(63,752)	20
21	Clerical & General Office Expenses	(3,864)	0	0	0	0	0	0	0	0	0	0	(3,864)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(3,017)	0	0	0	0	0	0	0	0	0	0	(3,017)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(416,555)	0	0	0	0	0	0	0	0	0	0	(416,555)	27
28	**TOTAL General Administration**	(466,242)	0	0	0	0	0	0	0	0	0	0	(466,242)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(1,188,208)	0	0	0	0	0	0	0	0	0	0	(1,188,208)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Du Page Convalescent Center # 0008201 **Report Period Beginning:** Dec. 1, 2000 **Ending:** Nov. 30, 2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(4,402)	0	0	0	0	0	0	0	0	0	0	(4,402)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(4,402)	0	0	0	0	0	0	0	0	0	0	(4,402)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	(19,722)	0	0	0	0	0	0	0	0	0	0	(19,722)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	278,130	0	0	0	0	0	0	0	0	0	0	278,130	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	258,408	0	0	0	0	0	0	0	0	0	0	258,408	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(934,202)	0	0	0	0	0	0	0	0	0	0	(934,202)	45

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: Dec. 1, 2000 Ending: Nov. 30, 2001

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
NONE						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V				$			$	$	1
2	V									2
3	V									3
4	V									4
5	V									5
6	V									6
7	V									7
8	V									8
9	V									9
10	V									10
11	V									11
12	V									12
13	V									13
14	Total				$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: Dec. 1, 2000 Ending: Nov. 30, 2001

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	NONE								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: Dec. 1, 2000 Ending: Nov. 30, 2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Du Page County Government
Street Address: 421 N. County Farm Road (Finance Dept)
City / State / Zip Code: Wheaton, Illinois 60187
Phone Number: (630) 682-7449
Fax Number: (630) 682-7964

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	I.M.R.F. & Social Security	Direct Cost	14,281,240	48	$ 14,281,240	$ 0	1,859,785	$ 1,859,785	1
2	19	Technical & Prof Services	Direct Cost	545,258	48	545,258	0	4,500	4,500	2
3	19	Finance & Auditor allocation	# of A/P Claims	485,622	167	485,622	256,192	86,447	86,447	3
4	19	County Audit	% of Time Spent	168,050	11	168,050	0	7,908	7,908	4
5	19	General Acctg & Budgeting	% of All Depts	872,911	49	872,911	417,568	17,458	17,458	5
6	21	Mail Delivery	Wtd Avg # of Del.	250,000	44	250,000	189,559	5,656	5,656	6
7	22	Workers Comp Claims	Direct Cost	700,401	48	700,401	0	165,376	165,376	7
8	22	Workers Comp Premiums	# of Claims	248,649	16	248,649	0	46,211	46,211	8
9	26	Auto Liability Claims	Direct Cost	1,165,974	48	1,165,974	0	2,618	2,618	9
10	26	Property Insurance	Building Value	112,620	43	112,620	0	9,582	9,582	10
11	26	Gen/Prof Liab Ins & Surety Bd	Direct Cost	791,558	48	791,558	0	403,263	403,263	11
12	22	Unempl Comp Prem & Exp	Direct Cost & FTEs	76,889	46	76,889	0	13,161	13,161	12
13	26	Service Retention Fee	# of Ins Claims	74,969	18	74,969	0	22,233	22,233	13
14	17	Maint of Grounds	Square Footage	619,464	54	619,464	323,744	97,237	97,237	14
15	5	Space & HVAC Allocation	Square Footage	6,272,068	48	6,272,068	1,947,766	1,002,282	1,002,282	15
16	17	Security	Square Footage	893,939	50	893,939	573,907	208,721	208,721	16
17	6	Building Maintenance	Direct Cost	2,313,800	35	2,313,800	718,541	592,164	592,164	17
18	21	Telecommunications	Direct Cost	1,049,921	43	1,049,921	0	432	432	18
19	6	Rental & Repair/Maint of Eqp	Direct Cost	127,767	43	127,767	0	4,895	4,895	19
20	17	Personnel Costs	% of Ads & FTEs	2,046,500	51	2,046,500	1,104,663	348,257	348,257	20
21	17	Purchasing Costs	# of Purchase Orders	609,178	37	609,178	311,503	40,161	40,161	21
22	17	County Administrator	Dept Size	324,000	20	324,000	324,000	18,000	18,000	22
23	17	County Board Allocation	Comm Assignments	984,317	51	984,317	984,317	20,946	20,946	23
24										24
25	TOTALS					$ 35,015,095	$ 7,151,760		$ 4,977,293	25

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: Dec. 1, 2000 Ending: Nov. 30, 2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	N/A						$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	N/A											6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10	N/A											10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: Dec. 1, 2000 Ending: Nov. 30, 2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1996	8
	1997	9
	1998	10
	1999	11
	2000	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Du Page Convalescent Center COUNTY Du Page

FACILITY IDPH LICENSE NUMBER 0008201

CONTACT PERSON REGARDING THIS REPORT James A. Freund

TELEPHONE (630) 665-6400, EXT. 7211 FAX #: (630) 665-9633

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	N/A		$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: Dec. 1, 2000 Ending: Nov. 30, 2001

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 257,371 B. General Construction Type: Exterior Masonry Rf. Concrete Frame Steel Number of Stories 5

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility Buildings	400,000	Various	$ 784,360	1
2					2
3	TOTALS	400,000		$ 784,360	3

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: Dec. 1, 2000 Ending: Nov. 30, 2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	288		1947	1947	$ 70,858	$	30	$	$	$ 70,858	4
5				1964	1,172,064	34,473	34	34,473		640,615	5
6	104			1978	4,456,548	148,552	30	148,552		3,503,342	6
7	16			1979	1,750,524	58,351	30	58,351		1,293,444	7
8	100			1993	6,516,821	259,038	Various	259,038		2,106,467	8
	Improvement Type**										
9	Mech. Room renovation & heat exchangers			1976	44,372		20			44,372	9
10	Alarm Equip doors & other, Project 181			1977	8,545		20			8,545	10
11	Cyclone Dust Collector			1978	12,188		20			12,188	11
12	Flagpole			1979	844		20			844	12
13	Kitchen Door replace / ground north remodeling			1981	212,304	6,946	20	6,946		212,304	13
14	South Bldg renovation - Phase III (Per 1989 Adj)			1983	3,782,867	189,143	20	189,143		3,592,852	14
15	South Bldg renovation - Phase III Architect Fees			1983	262,953	13,148	20	13,148		244,328	15
16	Laundry, 3-center & nurse station remodeling			1985	261,742	9,947	15/20	9,947		221,951	16
17	Tubs & Parking Lot projects & misc			1989	199,883	9,994	20	9,994		119,099	17
18	Oxygen Manifold - North Bldg			1990	5,423	271	20	271		2,960	18
19	Ground North & Hydrotherapy remodeling			1991	331,512	18,438	15/20/25	18,438		182,846	19
20	Window Replacement, 3-Center & Nurse Station remodeling			1992	604,207	33,377	10/15/20/25	33,377		318,463	20
21	Laundry Water Heater & softnrs, asphalt rep & landscaping			1993	588,826	34,963	10/12/15/20	34,963		279,727	21
22	ADA & elevator upgrades, nurse station remodel & misc			1994	105,577	6,790	5/10/15/20	6,790		52,294	22
23	Sewer Ejector pumps &carpet replacemnt			1995	31,457	2,776	5/10	2,776		22,434	23
24	Carpet replace, recreation & volunteer areas & misc			1996	7,963	408	5	408		7,963	24
25	Chilled Water Bridges, Liquid Oxygen, Lights refit & Elevatr			1997	320,587	19,102	5/10/20	19,102		83,290	25
26	Elevator Pit ladders, & automatic Entrance doors			1998	10,922	950	10/20	950		3,103	26
27	Lobby Remodeling, Carpet, Elevator safety system & HVAC			1999	701,043	76,792	5/10/20	76,792		154,280	27
28	Tubs, Reception, Laundry, Kitchen, Elev, HVAC & Access			2000	848,431	89,047	5/10/15/20	89,047		105,841	28
29	Tub Room Remodel, Life Safety Syst, Elev, Liq Oxygen Rm			2001	473,208	1,158	10	1,158		1,158	29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: Dec. 1, 2000 Ending: Nov. 30, 2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 22,781,669	$ 1,013,664		$ 1,013,664	$	$ 13,285,568	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: Dec. 1, 2000 Ending: Nov. 30, 2001

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 2,770,671	$ 273,829	$ 273,829	$	3/4/10	$ 1,423,917	71
72	Current Year Purchases	195,525	15,390	15,390		3/4/10	15,390	72
73	Fully Depreciated Assets	1,197,227					1,197,227	73
74								74
75	TOTALS	$ 4,163,423	$ 289,219	$ 289,219	$		$ 2,636,534	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Snowplow & Maint	Various	Various	$ 177,856	$ 15,125	$ 15,125	$	3/4/10	$ 163,986	76
77	Grounds Maint	John Deere Tractor	11/99	12,685	1,269	1,269		10	3,489	77
78	Maint & Transport	Ford A-10 Van	11/00	38,971	9,743	9,743		4	13,802	78
79	Maint & Transport	2001 Window Van	11/01	31,396				10		79
80	TOTALS			$ 260,908	$ 26,137	$ 26,137	$		$ 181,277	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 27,990,360	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 1,329,020	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 1,329,020	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 16,103,379	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	N/A			$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning N/A
Ending N/A

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO

16. Rental Amount for movable equipment: $ N/A Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: Dec. 1, 2000 Ending: Nov. 30, 2001

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

Training was not necessary for this Year.
All Aides hired were already trained or Certified.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: Dec. 1, 2000 Ending: Nov. 30, 2001

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service		Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist			hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist			hrs							2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	Ln 10a, Col 8	4214	hrs	129,054				4,214	129,054	4
5	Physician Care	Ln 10, Col 8		visits		4,602	24,000		4,602	24,000	5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy	Ln 39, Col 8	57143	# of prescrpts	330,075			2,324,635	57,143	2,654,710	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Exceptional Care Program	Ln 39, Col 8			528,423			184,039		712,462	12
13	Other (specify):										13
14	TOTAL				$ 987,552	4,602	$ 24,000	$ 2,508,674	65,959	$ 3,520,226	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: Dec. 1, 2000 Ending: Nov. 30, 2001

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of Nov. 30, 2001 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 30,511	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 500,000)	5,236,148		3
4	Supply Inventory (priced at Cost)	238,349		4
5	Short-Term Investments	940,000		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	126,934		7
8	Accounts Receivable (owners or related parties)	269		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 6,572,211	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	784,360		13
14	Buildings, at Historical Cost	22,870,017		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	4,394,839		16
17	Accumulated Depreciation (book methods)	(16,078,292)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe CIP	1,122,963		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 13,093,887	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 19,666,098	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,302,379	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	1,219,174		30
31	Accrued Taxes Payable (excluding real estate taxes)	130,371		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,651,924	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Accrued Vac & Sick Pay	87,684		43
44	Accrued Employee Retention	525,303		44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 612,987	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,264,911	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 16,401,187	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 19,666,098	$	48

***(See instructions.)**

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: Dec. 1, 2000 Ending: Nov. 30, 2001

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 18,363,425	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 18,363,425	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(6,529,807)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Reconciling unlocated variance**	106	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (6,529,701)	17
	B. Transfers (Itemize):		
18	**Contributed Capital**	3,767,675	18
19	**Donated Capital**	799,787	19
20	**Rounding**	1	20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 4,567,463	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 16,401,187	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: Dec. 1, 2000 Ending: Nov. 30, 2001

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 25,118,166	1
2	Discounts and Allowances for all Levels	(4,580,526)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 20,537,640	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,475,453	6
7	Oxygen	307,407	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,782,860	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	875	13
14	Non-Patient Meals	675,245	14
15	Telephone, Television and Radio	43,776	15
16	Rental of Facility Space		16
17	Sale of Drugs	1,972,063	17
18	Sale of Supplies to Non-Patients	(33,467)	18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	10,172	21
22	Laundry	2,944	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 2,671,608	23
	D. Non-Operating Revenue		
24	Contributions	20	24
25	Interest and Other Investment Income***	93,385	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 93,405	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 26,085,513	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	6,991,724	31
32	Health Care	15,597,524	32
33	General Administration	6,916,929	33
	B. Capital Expense		
34	Ownership	1,333,427	34
	C. Ancillary Expense		
35	Special Cost Centers	1,775,716	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 32,615,320	40
41	**Income before Income Taxes (line 30 minus line 40)****	(6,529,807)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (6,529,807)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? N/A If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: Dec. 1, 2000 Ending: Nov. 30, 2001

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	3,537	3,835	$ 210,225	$ 54.82	1
2	Assistant Director of Nursing	1,850	2,182	124,911	57.25	2
3	Registered Nurses	149,548	168,031	4,472,880	26.62	3
4	Licensed Practical Nurses	24,704	28,086	516,969	18.41	4
5	Nurse Aides & Orderlies	459,479	509,619	6,467,142	12.69	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	16,407	18,626	459,129	24.65	7
8	Rehab/Therapy Aides	23,081	26,739	368,650	13.79	8
9	Activity Director	1,650	1,915	104,573	54.61	9
10	Activity Assistants	27,344	31,193	445,136	14.27	10
11	Social Service Workers	15,908	18,038	306,359	16.98	11
12	Dietician	7,358	8,125	137,963	16.98	12
13	Food Service Supervisor	7,275	7,694	158,096	20.55	13
14	Head Cook	4,459	4,755	73,803	15.52	14
15	Cook Helpers/Assistants	57,305	61,916	646,290	10.44	15
16	Dishwashers	58,694	61,136	535,651	8.76	16
17	Maintenance Workers					17
18	Housekeepers	81,987	88,306	962,470	10.90	18
19	Laundry	19,020	21,157	252,371	11.93	19
20	Administrator	1,865	2,109	112,786	53.48	20
21	Assistant Administrator	1,849	2,109	82,904	39.31	21
22	Other Administrative	12,825	14,314	349,402	24.41	22
23	Office Manager					23
24	Clerical	45,095	50,233	754,569	15.02	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,894	2,060	62,737	30.45	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	5,137	5,881	78,292	13.31	31
32	Other Health C: Nrs Sec, W/C	25,926	29,398	454,304	15.45	32
33	Other(specify) Barber/Beautcn	8,449	9,408	129,965	13.81	33
34	TOTAL (lines 1 - 33)	1,062,646	1,176,865	$ 18,267,577 *	$ 15.52	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	499	$ 15,454	Ln 1, C 3	35
36	Medical Director				36
37	Medical Records Consultant	230	7,165	Ln 10, C 3	37
38	Nurse Consultant	524	26,200	Ln 10, C 3	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	8,660	311,565	Ln 10a,C 3	40
41	Occupational Therapy Consultant	5,521	208,750	Ln 10a,C 3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	1,685	46,322	Ln 10a,C 3	43
44	Activity Consultant	16	832	Ln 11, C 3	44
45	Social Service Consultant	52	2,730	Ln 12, C 3	45
46	Other(specify) Medicare Conslt	255	9,189	Ln 21, C 3	46
47	Medicare PPS Consultant	50	6,000	Ln 19, C 3	47
48	Housekeeping Comp Conslt	58	4,640	Ln 3, C 3	48
49	TOTAL (lines 35 - 48)	17,550	$ 638,847		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	111	$ 5,105	Ln 10, C 3	50
51	Licensed Practical Nurses	258	9,120	Ln 10, C 3	51
52	Nurse Aides	3,439	68,544	Ln 10, C 3	52
53	TOTAL (lines 50 - 52)	3,808	$ 82,769		53

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: Dec. 1, 2000 Ending: Nov. 30, 2001

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Maureen T. Mc Hugh	Administrator	None	$ 112,786
Beth McGowan Welch	Asst. Administr	None	82,905
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 195,691

B. Administrative - Other

Description	Amount
Other Contractual Expenses	$ 611,069
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 611,069

C. Professional Services

Vendor/Payee	Type	Amount
County Acctg & Auditor	Acctg & Audit Svcs	$ 111,813
County Data Proc	Tech/Data Proc Svcs	4,500
Strategic Reimb. Svcs, Inc.	Cost Report Svcs	26,022
Cini Little Int.	Design Srvcs	4,022
United Methodist Homes	Admin Nsg Svcs	7,700
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 154,057

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 211,586
Unemployment Compensation Insurance	13,161
FICA Taxes	1,348,810
Employee Health Insurance	1,369,106
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	510,975
Accrued Comp Expense	(63,928)
Employee Svc Awards	2,819
TOTAL (agree to Schedule V, line 22, col.8)	$ 3,392,529

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 84)	588
Life Srvcs Network of Illinois	41,639
NAGNA	4,488
DuPage County Treasurer	1,300
Amer Physical Ther Association	1,081
Dupage Conv Ctr	790
Various Other small amts per sch	4,277
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 54,163

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 3,017
In-State Travel	3,809
Seminar Expense	45,414
Entertainment Expense	(3,017)
TOTAL (agree to Sch. V, line 24, col. 8)	$ 49,223

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Du Page Convalescent Center # 0008201 Report Period Beginning: Dec. 1, 2000 Ending: Nov. 30, 2001

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **NO**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **171,928** Line **10, Col 2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **278,130**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **NONE** Has any meal income been offset against related costs? **YES** Indicate the amount. $ **675,246**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **NONE**
d. Have vehicle usage logs been maintained? **YES**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **NONE**

(17) Has an audit been performed by an independent certified public accounting firm? **YES**
Firm Name: **WOLF & COMPANY CPA's** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **NO** If no, please explain. **Final Not Yet Available**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.